State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–2476/P4
PJK:kmg:cph

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 149.10 (8b), 149.14 (3) (a) to (r), 149.14 (4), 149.14 (4c), 149.15 (3) (c), 149.15 (3) (f), 149.15 (5) and 149.16; ***to renumber and amend*** 149.14 (3) (intro.); ***to amend*** 25.55 (3), 149.10 (3), 149.11, 149.12 (3) (c), 149.13 (1), 149.13 (3), 149.13 (4), 149.14 (5) (d), 149.14 (5) (e), 149.14 (5m) (c), 149.14 (7) (b) and (c), 149.14 (8), 149.142 (1), 149.143 (1) (intro.), 149.143 (1) (b) 1. a., 149.143 (1) (b) 1. c., 149.143 (1) (b) 1. d., 149.143 (1) (b) 2. a., 149.143 (1) (b) 2. b., 149.143 (2) (a) (intro.), 149.143 (2) (a) 2., 149.143 (2) (a) 3., 149.143 (2) (a) 4., 149.143 (2) (b), 149.143 (2m) (a) (intro.), 149.143 (2m) (b) 1., 149.143 (2m) (b) 2., 149.143 (2m) (b) 3., 149.143 (3) (a), 149.143 (3) (b), 149.143 (3m), 149.143 (4), 149.143 (5), 149.144, 149.145, 149.146 (1) (b), 149.146 (2) (a), 149.146 (2) (am) 4., 149.146 (2) (am) 5., 149.146 (2) (b) (intro.), 149.146 (2) (b) 1., 149.146 (2) (b) 2., 149.15 (1), 149.165 (1), 149.165 (2), 149.165 (3) (a), 149.165 (3) (b) (intro.), 149.17 (4), 149.175, 149.20, 149.25 (2) (a), 149.25 (2) (c) 1., 149.25 (2) (c) 2., 149.25 (3) (a) (intro.) and 149.25 (4); ***to repeal and recreate*** 149.13 (2); and ***to create*** 149.10 (2p), 149.10 (2r), 149.132, 149.143 (1) (b) 2. am., 149.143 (2)

(a) 3m., 149.143 (2m) (c), 149.15 (3) (b), 149.15 (3) (e), 149.15 (3) (em), 149.15 (4) (c) and 450.10 (2m) of the statutes; **relating to:** making various miscellaneous changes to the Health Insurance Risk–Sharing Plan and granting rule–making authority.

Analysis by the Legislative Reference Bureau

This draft will be converted to an amendment to the budget.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 25.55 (3) of the statutes is amended to read:

25.55 **(3)** Insurer and drug manufacturer ~~and distributor~~ assessments under ch. 149.

SECTION 2. 149.10 (2p) of the statutes is created to read:

149.10 **(2p)** "Drug distributor" means a person licensed by the pharmacy examining board under s. 450.07 (2).

SECTION 3. 149.10 (2r) of the statutes is created to read:

149.10 **(2r)** "Drug manufacturer" means a person licensed by the pharmacy examining board under s. 450.07 (1).

SECTION 4. 149.10 (3) of the statutes is amended to read:

149.10 **(3)** "Eligible person" means a resident ~~of this state~~ who qualifies under s. 149.12 whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf.

SECTION 5. 149.10 (8b) of the statutes is repealed.

SECTION 6. 149.11 of the statutes is amended to read:

149.11 Operation of plan. The ~~department~~ board shall promulgate rules for the design and operation of a plan of health insurance coverage for ~~an~~ eligible ~~person which~~ persons that satisfies the requirements of this chapter. The board shall consult with the department as necessary in promulgating the rules under this section. The department shall provide the board with the support necessary for the board to carry out its responsibilities under this chapter.

SECTION 7. 149.12 (3) (c) of the statutes is amended to read:

149.12 **(3)** (c) The ~~department~~ board may promulgate rules specifying other deductible or coinsurance amounts that, if paid or reimbursed for persons, will not make the persons ineligible for coverage under the plan.

SECTION 8. 149.13 (1) of the statutes is amended to read:

149.13 **(1)** Every insurer shall participate in the cost of administering the plan, except that the commissioner may by rule exempt as a class those insurers whose share as determined under sub. ~~(2)~~ (3) would be so minimal as ~~to~~ not to exceed the estimated cost of levying the assessment. The commissioner shall advise the ~~department~~ board of the insurers participating in the cost of administering the plan.

SECTION 9. 149.13 (2) of the statutes is repealed and recreated to read:

149.13 **(2)** The board shall develop a methodology for apportioning insurer assessments among insurers that are stop loss carriers and insurers that are not stop loss carriers. The board shall consult with the commissioner as necessary in developing the methodology under this subsection.

SECTION 10. 149.13 (3) of the statutes is amended to read:

149.13 **(3)** (a) Each insurer's proportion of participation ~~under sub. (2)~~ shall be determined annually by the commissioner ~~based on~~, in conformity with the methodology determined under sub. (2), on the basis of annual statements and other

reports filed by the insurer with the commissioner. The commissioner shall assess an insurer for the insurer's proportion of participation based on the total assessments estimated by the ~~department~~ under s. 149.143 (2) (a) 3.

(b) If the department ~~or the~~, commissioner, or board finds that the commissioner's authority to require insurers to report under chs. 600 to 646 and 655 is not adequate to permit the department, the commissioner, or the board to carry out the department's, commissioner's, or board's responsibilities under this chapter, the commissioner shall promulgate rules requiring insurers to report the information necessary for the department, commissioner, and board to make the determinations required under this chapter.

SECTION 11. 149.13 (4) of the statutes is amended to read:

149.13 **(4)** Notwithstanding subs. (1) to (3), the department, with the agreement of the commissioner and the board, may perform various administrative functions related to the assessment of insurers participating in the cost of administering the plan.

SECTION 12. 149.132 of the statutes is created to read:

149.132 Participation of drug manufacturers and distributors. (1) For the privilege of doing business in the state, every drug manufacturer and drug distributor shall share in the operating, administrative, and subsidy expenses of the plan in the manner provided in ss. 149.143 and 149.144, except that the board may by rule exempt as a class those drug manufacturers and drug distributors whose share as determined under sub. (2) would be so minimal as not to exceed the estimated cost of levying the assessment.

(2) The board shall determine the methodology for assessing drug manufacturers and drug distributors, including each drug manufacturer's or

distributor's proportion of participation in the costs of the plan. ~~Assessments~~ shall be determined annually and shall be based on a drug manufacturer's ~~or distributor's~~ gross revenues derived from business done in the state in the preceding calendar year. In determining the assessments under this section, the board shall consider a drug manufacturer's or distributor's gross revenues in the preceding calendar year from prescription drugs provided to residents receiving medical assistance, as determined by the department. The board shall consult with the department as necessary in determining the methodology under this subsection.

(3) The department shall advise the pharmacy examining board of the assessment amounts that must be levied. The pharmacy examining board shall levy and collect the assessments and forward the amounts collected to the department for deposit in the health insurance risk–sharing plan fund.

SECTION 13. 149.14 (3) (intro.) of the statutes is renumbered 149.14 (3) and amended to read:

149.14 **(3)** COVERED EXPENSES. Except as ~~provided in sub. (4), except as~~ restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the ~~department~~ board under ss. 149.143 and 149.144, covered expenses for the coverage under this section shall be the payment rates established ~~by the department~~ under s. 149.142 for the services provided by persons licensed under ch. 446 and certified under s. 49.45 (2) (a) 11. Except as ~~provided in sub. (4), except as~~ restricted by cost containment provisions under s. 149.17 (4) and except as reduced by the ~~department~~ board under ss. 149.143 and 149.144, covered expenses for the coverage under this section shall also be the payment rates established ~~by the department~~ under s. 149.142 for the ~~following~~ services and articles specified by the board if the service or article is prescribed by a physician who is licensed under ch.

448 or in another state and who is certified under s. 49.45 (2) (a) 11. and if the service or article is provided by a provider certified under s. 49.45 (2) (a) 11.~~.~~

SECTION 14. 149.14 (3) (a) to (r) of the statutes are repealed.

SECTION 15. 149.14 (4) of the statutes is repealed.

SECTION 16. 149.14 (4c) of the statutes is repealed.

SECTION 17. 149.14 (5) (d) of the statutes is amended to read:

149.14 **(5)** (d) Notwithstanding pars. (a) to (c), the ~~department~~ board may establish different deductible amounts, a different coinsurance percentage, and different covered costs and deductible aggregate amounts from those specified in pars. (a) to (c) in accordance with cost containment provisions established by the ~~department~~ board under s. 149.17 (4).

SECTION 18. 149.14 (5) (e) of the statutes is amended to read:

149.14 **(5)** (e) Subject to sub. (8) (b), the ~~department~~ board may, by rule under s. 149.17 (4), establish for prescription drug coverage under ~~sub. (3) (d)~~ this section copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which the plan will pay 100% of covered costs ~~under sub. (3) (d). Any copayment amount, coinsurance rate, or out–of–pocket limit established under this paragraph is subject to the approval of the board~~ for prescription drugs. Copayments and coinsurance paid by an eligible person under this paragraph are separate from and do not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

SECTION 19. 149.14 (5m) (c) of the statutes is amended to read:

149.14 **(5m)** (c) Other economic factors that the ~~department and the~~ board ~~consider~~ considers relevant.

SECTION 20. 149.14 (7) (b) and (c) of the statutes are amended to read:

149.14 **(7)** (b) The ~~department~~ board has a cause of action against an eligible ~~participant~~ person for the recovery of the amount of benefits paid ~~which~~ that are not for covered expenses under the plan. Benefits under the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(c) The ~~department~~ board is subrogated to the rights of an eligible person to recover special damages for illness or injury to the person caused by the act of a 3rd person to the extent that benefits are provided under the plan. Section 814.03 (3) applies to the ~~department~~ board under this paragraph.

SECTION 21. 149.14 (8) of the statutes is amended to read:

149.14 **(8)** APPLICABILITY OF ~~MEDICAL ASSISTANCE~~ MEDICAL ASSISTANCE PROVISIONS. (a) Except as provided in par. (b), the ~~department~~ board may, by rule under s. 149.17 (4), apply to the plan the same utilization and cost control procedures that apply under rules promulgated by the department to ~~medical assistance~~ Medical Assistance ~~under subch. IV of ch. 49~~. The board shall consult with the department as necessary in the application of the utilization and cost control procedures specified in this paragraph.

(b) The ~~department~~ board may not apply to eligible persons for covered services or articles the same copayments that apply to recipients of ~~medical assistance~~ Medical Assistance ~~under subch. IV of ch. 49~~ for services or articles covered under that program.

SECTION 22. 149.142 (1) of the statutes is amended to read:

149.142 **(1)** (a) Except as provided in par. (b), the ~~department~~ board shall establish payment rates for covered expenses that consist of the allowable charges paid under s. 49.46 (2) for the services and articles provided plus an enhancement determined by the ~~department~~ board. The rates shall be based on the allowable

charges paid under s. 49.46 (2), projected plan costs, and trend factors. Using the same methodology that applies to ~~medical assistance~~ ~~Medical Assistance~~ ~~under subch. IV of ch. 49,~~ the ~~department~~ board shall establish hospital outpatient per visit reimbursement rates and hospital inpatient reimbursement rates that are specific to diagnostically related groups of eligible persons. The board shall consult with the department in establishing the payment and reimbursement rates under this paragraph.

(b) The payment rate for a prescription drug shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4), the ~~department~~ board may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and the rate may not be adjusted under s. 149.143 or 149.144.

SECTION 23. 149.143 (1) (intro.) of the statutes is amended to read:

149.143 **(1)** (intro.) The department shall pay or recover the operating costs of the plan from the appropriation under s. 20.435 (4) (v) and administrative costs of the plan from the appropriation under s. 20.435 (4) (u). For purposes of determining premiums, insurer and drug manufacturer ~~and distributor~~ assessments, and provider payment rate adjustments, the ~~department~~ board shall apportion and prioritize responsibility for payment or recovery of plan costs from among the moneys constituting the fund as follows:

SECTION 24. 149.143 (1) (b) 1. a. of the statutes is amended to read:

149.143 **(1)** (b) 1. a. First, from premiums from eligible persons with coverage under s. 149.14 (2) (a) set at a rate that is 140% to 150% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as are provided under the plan and

from eligible persons with coverage under s. 149.14 (2) (b) set in accordance with s. 149.14 (5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah), and from premiums collected from eligible persons with coverage under s. 149.146 set in accordance with s. 149.146 (2) (b).

SECTION 25. 149.143 (1) (b) 1. c. of the statutes is amended to read:

149.143 **(1)** (b) 1. c. Third, by increasing premiums from eligible persons with coverage under s. 149.14 (2) (a) to more than the rate at which premiums were set under subd. 1. a. but not more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as are provided under the plan and from eligible persons with coverage under s. 149.14 (2) (b) by a comparable amount in accordance with s. 149.14 (5m), including amounts received for premium and deductible subsidies under s. 149.144 and under the transfer to the fund from the appropriation account under s. 20.435 (4) (ah), and by increasing premiums from eligible persons with coverage under s. 149.146 in accordance with s. 149.146 (2) (b), to the extent that the amounts under subd. 1. a. and b. are insufficient to pay 60% of plan costs.

SECTION 26. 149.143 (1) (b) 1. d. of the statutes is amended to read:

149.143 **(1)** (b) 1. d. Fourth, notwithstanding subd. 2., by increasing insurer assessments, excluding assessments under s. 149.144, increasing drug manufacturer ~~and drug distributor~~ assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subd. 1. a. to c. are insufficient to pay 60% of plan costs.

SECTION 27. 149.143 (1) (b) 2. a. of the statutes is amended to read:

149.143 **(1)** (b) 2. a. ~~Fifty–percent~~ One–third from insurer assessments, excluding assessments under s. 149.144.

SECTION 28. 149.143 (1) (b) 2. am. of the statutes is created to read:

149.143 **(1)** (b) 2. am. One–third from drug manufacturer ~~and drug distributor~~ assessments, excluding assessments under s. 149.144.

SECTION 29. 149.143 (1) (b) 2. b. of the statutes is amended to read:

149.143 **(1)** (b) 2. b. ~~Fifty–percent~~ One–third from adjustments to provider payment rates, subject to s. 149.142 (1) (b) and excluding adjustments to those rates under s. 149.144.

SECTION 30. 149.143 (2) (a) (intro.) of the statutes is amended to read:

149.143 **(2)** (a) (intro.) Prior to each plan year, the ~~department~~ board shall estimate the operating and administrative costs of the plan and the costs of the premium reductions under s. 149.165 and the deductible reductions under s. 149.14 (5) (a) for the new plan year and do all of the following:

SECTION 31. 149.143 (2) (a) 2. of the statutes is amended to read:

149.143 **(2)** (a) 2. After making the determinations under subd. 1., by rule set premium rates for the new plan year, including the rates under s. 149.146 (2) (b), in the manner specified in sub. (1) (b) 1. a. and c. and such that a rate for coverage under s. 149.14 (2) (a) is ~~approved by the board and is~~ not less than 140% nor more than 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as are provided under the plan.

SECTION 32. 149.143 (2) (a) 3. of the statutes is amended to read:

149.143 **(2)** (a) 3. By rule set the total insurer assessments under s. 149.13 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. a., and the department shall notify the commissioner of the amount.

SECTION 33. 149.143 (2) (a) 3m. of the statutes is created to read:

149.143 **(2)** (a) 3m. By the same rule as under subd. 3., set the total drug manufacturer ~~and drug distributor~~ assessments under s. 149.132 for the new plan year by estimating and setting the assessments at the amount necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. am., and the department shall notify the pharmacy examining board of the amount.

SECTION 34. 149.143 (2) (a) 4. of the statutes is amended to read:

149.143 **(2)** (a) 4. By the same rule as under ~~subd. 3.~~ subds. 3. and 3m., adjust the provider payment rate for the new plan year, subject to s. 149.142 (1) (b), by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (b) 1. d. and 2. b. and as provided in s. 149.145.

SECTION 35. 149.143 (2) (b) of the statutes is amended to read:

149.143 **(2)** (b) In setting the premium rates under par. (a) 2., the insurer assessment amount under par. (a) 3., the drug manufacturer ~~and drug distributor~~ assessment amount under par. (a) 3m., and the provider payment rate under par. (a) 4. for the new plan year, the ~~department~~ board shall include any increase or decrease necessary to reflect the amount, if any, by which the rates and amount set under par. (a) for the current plan year differed from the rates and amount which would have equaled the amounts specified in sub. (1) (b) in the current plan year.

SECTION 36. 149.143 (2m) (a) (intro.) of the statutes is amended to read:

149.143 **(2m)** (a) (intro.) The ~~department~~ board shall keep a separate accounting of the difference between the following:

SECTION 37. 149.143 (2m) (b) 1. of the statutes is amended to read:

149.143 **(2m)** (b) 1. To reduce premiums in succeeding plan years as provided in sub. (1) (b) 1. b. For eligible persons with coverage under s. 149.14 (2) (a), premiums may not be reduced below 140% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as are provided under the plan.

SECTION 38. 149.143 (2m) (b) 2. of the statutes is amended to read:

149.143 **(2m)** (b) 2. For other needs of eligible persons~~, with the approval of the board~~.

SECTION 39. 149.143 (2m) (b) 3. of the statutes is amended to read:

149.143 **(2m)** (b) 3. For distribution to eligible persons, notwithstanding any requirements in this chapter related to setting premium amounts. The ~~department~~ board, with the ~~approval of the board and the~~ concurrence of the plan actuary, shall determine the policies, eligibility criteria, methodology, and other factors to be used in making any distribution under this subdivision.

SECTION 40. 149.143 (2m) (c) of the statutes is created to read:

149.143 **(2m)** (c) The board shall consult with the department as necessary for the accounting under par. (a).

SECTION 41. 149.143 (3) (a) of the statutes is amended to read:

149.143 **(3)** (a) If, during a plan year, the ~~department~~ board determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer and drug manufacturer ~~and drug distributor~~ assessments and the provider payment rate under s. 149.144 will not be

sufficient to cover plan costs, the ~~department~~ board may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. and 3m. for the remainder of the plan year, subject to sub. (1) (b) 2. a. and am., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (b) 2. b. and s. 149.142 (1) (b).

SECTION 42. 149.143 (3) (b) of the statutes is amended to read:

149.143 **(3)** (b) If the ~~department~~ board increases premium rates and insurer and drug manufacturer ~~and drug distributor~~ assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the ~~department~~ board may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and 3m. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (b) 2. but subject to s. 149.142 (1) (b).

SECTION 43. 149.143 (3m) of the statutes is amended to read:

149.143 **(3m)** Subject to s. 149.14 (4m), insurers, drug manufacturers, ~~drug distributors,~~ and providers may recover in the normal course of their respective businesses without time limitation assessments or provider payment rate adjustments used to recoup any deficit incurred under the plan.

SECTION 44. 149.143 (4) of the statutes is amended to read:

149.143 **(4)** Using the procedure under s. 227.24, the ~~department~~ board may promulgate rules under sub. (2) or (3) for the period before the effective date of any permanent rules promulgated under sub. (2) or (3), but not to exceed the period

authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the ~~department~~ board is not required to make a finding of emergency.

SECTION 45. 149.143 (5) of the statutes is amended to read:

149.143 **(5)** (a) Annually, no later than April 30, the ~~department~~ board shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, drug manufacturer ~~and drug distributor~~ assessments, and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the ~~department~~ board shall make any necessary adjustments in premiums, insurer assessments, drug manufacturer ~~or distributor~~ assessments, or provider payment rates, subject to s. 149.142 (1) (b), for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b). The board shall consult with the department as necessary in performing the reconciliation and in making the adjustments under this paragraph.

(b) Except as provided in sub. (3) and s. 149.144, the ~~department~~ board shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually, subject to s. 149.142 (1) (b). ~~The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate, subject to s. 149.142 (1) (b).~~

SECTION 46. 149.144 of the statutes is amended to read:

149.144 Adjustments to ~~insurer~~ assessments and ~~provider~~ payment rates for premium and deductible reductions. If the moneys transferred to the fund under the appropriation under s. 20.435 (4) (ah) are insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), or the ~~department~~ board determines that the moneys transferred or

to be transferred to the fund under the appropriation under s. 20.435 (4) (ah) will be insufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a), the ~~department~~ board may, by rule, adjust in equal proportions the ~~amount~~ amounts of the ~~assessment~~ assessments set under s. 149.143 (2) (a) 3. and 3m. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to ss. 149.142 (1) (b) and 149.143 (1) (b) 1., sufficient to reimburse the plan for premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a). If the ~~department~~ board makes the adjustment under this section, the department shall notify the commissioner and the pharmacy examining board so that the commissioner may levy any necessary increase in insurer assessments and the pharmacy examining board may levy any necessary increase in drug manufacturer ~~and drug distributor~~ assessments.

SECTION 47. 149.145 of the statutes is amended to read:

149.145 Program budget. The ~~department, in consultation with the~~ board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in s. 149.143 (1), including the methodologies specified in ss. 149.143, 149.144, and 149.146 for determining premium rates, insurer and drug manufacturer ~~and distributor~~ assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) and subject to s. 149.142 (1) (b), from the program budget the ~~department~~ board shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. ~~The department may not implement a program budget~~

~~established under this section unless it is approved by the~~ board shall consult with the department as necessary in deriving the actual provider payment rate.

SECTION 48. 149.146 (1) (b) of the statutes is amended to read:

149.146 **(1)** (b) An eligible person under par. (a) may elect once each year, at the time and according to procedures established by the ~~department~~ board, among the coverages offered under this section and s. 149.14. If an eligible person elects new coverage, any preexisting condition exclusion imposed under the new coverage is met to the extent that the eligible person has been previously and continuously covered under this chapter. No preexisting condition exclusion may be imposed on an eligible person who elects new coverage if the person was an eligible individual when first covered under this chapter and the person remained continuously covered under this chapter up to the time of electing the new coverage.

SECTION 49. 149.146 (2) (a) of the statutes is amended to read:

149.146 **(2)** (a) Except as specified by the ~~department~~ board, the terms of coverage under s. 149.14, including deductible reductions under s. 149.14 (5) (a), do not apply to the coverage offered under this section. Premium reductions under s. 149.165 do not apply to the coverage offered under this section.

SECTION 50. 149.146 (2) (am) 4. of the statutes is amended to read:

149.146 **(2)** (am) 4. Notwithstanding subds. 1. to 3., the ~~department~~ board may establish different deductible amounts, a different coinsurance percentage, and different covered costs and deductible aggregate amounts from those specified in subds. 1. to 3. in accordance with cost containment provisions established by the ~~department~~ board under s. 149.17 (4).

SECTION 51. 149.146 (2) (am) 5. of the statutes is amended to read:

149.146 **(2)** (am) 5. Subject to s. 149.14 (8) (b), the ~~department~~ board may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which the plan will pay 100% of covered costs for prescription drugs. ~~Any copayment amount, coinsurance rate, or out–of–pocket limit established under this subdivision is subject to the approval of the board.~~ Copayments and coinsurance paid by an eligible person under this subdivision are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

SECTION 52. 149.146 (2) (b) (intro.) of the statutes is amended to read:

149.146 **(2)** (b) (intro.) The schedule of premiums for coverage under this section shall be promulgated by rule by the ~~department~~ board, as provided in s. 149.143. The rates for coverage under this section shall be set such that they differ from the rates for coverage under s. 149.14 (2) (a) by the same percentage as the percentage difference between the following:

SECTION 53. 149.146 (2) (b) 1. of the statutes is amended to read:

149.146 **(2)** (b) 1. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as provided under s. 149.14 (2) (a) and (5) ~~(a)~~.

SECTION 54. 149.146 (2) (b) 2. of the statutes is amended to read:

149.146 **(2)** (b) 2. The rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as the coverage offered under this section.

SECTION 55. 149.15 (1) of the statutes is amended to read:

149.15 **(1)** The plan shall ~~have~~ operate under the direction of a board of governors consisting of representatives of 2 participating insurers that are nonprofit corporations, representatives of 2 other participating insurers, ~~3~~ 4 health care provider representatives, including one representative of the ~~State~~ Wisconsin Medical Society ~~of Wisconsin~~, one representative of the Wisconsin Health and Hospital Association, one representative of the Pharmacy Society of Wisconsin, and one representative of an integrated multidisciplinary health system, and 4 public members, including one representative of small businesses in the state, appointed by the secretary for staggered 3–year terms. In addition, the commissioner, or a designated representative from the office of the commissioner, and the secretary, or a designated representative from the department, shall be ex officio nonvoting members of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital, or an insurer. At least one of the public members shall be an individual who has coverage under the plan. The ~~secretary or the secretary's representative shall be~~ board annually shall select the chairperson of the board. Board members, except the commissioner or the commissioner's representative and the secretary or the secretary's representative, shall be compensated at the rate of $50 per diem plus actual and necessary expenses.

SECTION 56. 149.15 (3) (b) of the statutes is created to read:

149.15 **(3)** (b) Establish by rule the plan design, including covered benefits and exclusions. At least every 3 years, the board shall conduct a survey of health care plans available in the private market and make any adjustments to the plan that the board determines are advisable on the basis of the survey. Using the procedure under s. 227.24, the board may promulgate rules under this paragraph for the period before the effective date of any permanent rules promulgated under this paragraph, but not

to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the board is not required to make a finding of emergency.

SECTION 57. 149.15 (3) (c) of the statutes is repealed.

SECTION 58. 149.15 (3) (e) of the statutes is created to read:

149.15 **(3)** (e) Select a plan administrator in a competitive, request–for–proposals process and enter into a contract with the person selected.

SECTION 59. 149.15 (3) (em) of the statutes is created to read:

149.15 **(3)** (em) Contract with persons to provide professional services to the board and the plan.

SECTION 60. 149.15 (3) (f) of the statutes is repealed.

SECTION 61. 149.15 (4) (c) of the statutes is created to read:

149.15 **(4)** (c) Notwithstanding ss. 625.11 (4) and 628.34 (3) (a) and any requirements in this chapter related to setting premium rates or amounts, establish for eligible persons with household incomes that exceed $100,000 a separate schedule of premium rates that are higher than the rates set for other eligible persons. Premium rates established under this paragraph may not exceed 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles that are provided under the plan. Notwithstanding s. 149.143 (2m) (b), the board may use excess premiums collected under a schedule established under this paragraph to reduce premiums for eligible persons with low household incomes, as determined by the board. Household income under this paragraph shall be determined in the same manner as household income is determined under s. 149.165 (2) and (3).

SECTION 62. 149.15 (5) of the statutes is repealed.

SECTION 63. 149.16 of the statutes is repealed.

SECTION 64. 149.165 (1) of the statutes is amended to read:

149.165 **(1)** Except as provided in s. 149.146 (2) (a), the ~~department~~ board shall reduce the premiums established ~~under s. 149.11~~ in conformity with ss. 149.14 (5m), 149.143, and 149.17 for the eligible persons and in the manner set forth in subs. (2) and (3).

SECTION 65. 149.165 (2) of the statutes is amended to read:

149.165 **(2)** (a) Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. 149.14 (2) (a) is equal to or greater than the first amount and less than the 2nd amount listed in any of the following, the ~~department~~ board shall reduce the premium for the eligible person to the rate shown after the amounts:

1. If equal to or greater than $0 and less than $10,000, to 100% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as provided under s. 149.14 (2) (a) and (5) ~~(a)~~.

2. If equal to or greater than $10,000 and less than $14,000, to 106.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as provided under s. 149.14 (2) (a) and (5) ~~(a)~~.

3. If equal to or greater than $14,000 and less than $17,000, to 115.5% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as provided under s. 149.14 (2) (a) and (5) ~~(a)~~.

4. If equal to or greater than $17,000 and less than $20,000, to 124.5% of the rate that a standard risk would be charged under an individual policy providing

substantially the same coverage and ~~deductibles~~ cost–sharing provisions as provided under s. 149.14 (2) (a) and (5) ~~(a)~~.

5. If equal to or greater than $20,000 and less than $25,000, to 130% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and ~~deductibles~~ cost–sharing provisions as provided under s. 149.14 (2) (a) and (5) ~~(a)~~.

(bc) Subject to sub. (3m), if the household income, as defined in s. 71.52 (5) and as determined under sub. (3), of an eligible person with coverage under s. 149.14 (2) (b) is equal to or greater than the first amount and less than the 2nd amount listed in par. (a) 1., 2., 3., 4., or 5., the ~~department~~ board shall reduce the premium established for the eligible person by the same percentage as the ~~department~~ board reduces, under par. (a), the premium established for an eligible person with coverage under s. 149.14 (2) (a) who has a household income specified in the same subdivision under par. (a) as the household income of the eligible person with coverage under s. 149.14 (2) (b).

SECTION 66. 149.165 (3) (a) of the statutes is amended to read:

149.165 **(3)** (a) Subject to par. (b), the ~~department~~ board shall establish and implement the method for determining the household income of an eligible person under sub. (2).

SECTION 67. 149.165 (3) (b) (intro.) of the statutes is amended to read:

149.165 **(3)** (b) (intro.) In determining household income under sub. (2), the ~~department~~ board shall consider information submitted by an eligible person on a completed federal profit or loss from farming form, schedule F, if all of the following apply:

SECTION 68. 149.17 (4) of the statutes is amended to read:

149.17 **(4)** Cost containment provisions established by the ~~department~~ board by rule, including managed care requirements.

SECTION 69. 149.175 of the statutes is amended to read:

149.175 Waiver or exemption from provisions prohibited. Except as provided in s. 149.13 (1), the department or the board may not waive~~, or authorize the board to waive,~~ any of the requirements of this chapter or exempt~~, or authorize the board to exempt,~~ an individual or a class of individuals from any of the requirements of this chapter.

SECTION 70. 149.20 of the statutes is amended to read:

149.20 ~~Rule–making in consultation with~~ Rules to be approved by board. ~~In promulgating any~~ Any rules proposed by the department under this chapter~~, the department shall consult with~~ may not be promulgated without the approval of the board.

SECTION 71. 149.25 (2) (a) of the statutes is amended to read:

149.25 **(2)** (a) The ~~department~~ board shall conduct a 3–year pilot program, beginning on July 1, 2002, under which eligible persons who qualify under par. (b) are provided community–based case management services. The board shall consult with the department as necessary in conducting the pilot program.

SECTION 72. 149.25 (2) (c) 1. of the statutes is amended to read:

149.25 **(2)** (c) 1. Participation in the pilot program shall be voluntary and limited to no more than 300 eligible persons. The ~~department~~ board shall ensure that all eligible persons are advised in a timely manner of the opportunity to participate in the pilot program and of how to apply for participation.

SECTION 73. 149.25 (2) (c) 2. of the statutes is amended to read:

149.25 **(2)** (c) 2. If more than 300 eligible persons apply to participate, the ~~department~~ board shall select pilot program participants from among those who qualify under par. (b) according to standards determined by the ~~department~~ board, except that the ~~department~~ board shall give preference to eligible persons who reside in medically underserved areas or health professional shortage areas.

SECTION 74. 149.25 (3) (a) (intro.) of the statutes is amended to read:

149.25 **(3)** (a) (intro.) The ~~department~~ board shall select and contract with an organization to provide the community–based case management services under the pilot program. To be eligible to provide the services, an organization must satisfy all of the following criteria:

SECTION 75. 149.25 (4) of the statutes is amended to read:

149.25 **(4)** EVALUATION STUDY. The department, in consultation with the board, shall conduct a study that evaluates the pilot program in terms of health care outcomes and cost avoidance. In the study, the department shall measure and compare, for pilot program participants and similarly situated eligible persons not participating in the pilot program, plan costs and utilization of services, including inpatient hospital days, rates of hospital readmission within 30 days for the same diagnosis, and prescription drug utilization. The department shall submit a report on the results of the study, including the department's and the board's conclusions and recommendations, to the legislature under s. 13.172 (2) and to the governor.

SECTION 76. 450.10 (2m) of the statutes is created to read:

450.10 **(2m)** If a manufacturer ~~or distributor~~ fails to pay an assessment levied under s. 149.132 (3) within the time required for payment, the board may assess a forfeiture of not more than $1,000 for each day that the payment is past due.

SECTION 9124. Nonstatutory provisions; health and family services.

(1) GENERAL FUND APPROPRIATIONS. Notwithstanding section 16.42 (1) (e) of the statutes, in submitting information under section 16.42 of the statutes for purposes of the 2005–07 biennial budget bill, the department of health and family services shall submit information concerning the appropriation under section 20.435 (4) (af) of the statutes as though the amount appropriated to the department under that appropriation for fiscal year 2004–05 were $9,500,000 more than the amount in the schedule and shall submit information concerning the appropriation under section 20.435 (4) (ah) of the statutes as though the amount appropriated to the department under that appropriation for fiscal year 2004–05 were $741,800 more than the amount in the schedule.

(2) SELECTION OF PLAN ADMINISTRATOR. The board of governors of the Health Insurance Risk–Sharing Plan shall, no later than December 1, 2003, issue a request–for–proposals under section 149.15 (3) (e) of the statutes, as created by this act, for administration of the Health Insurance Risk–Sharing Plan.

SECTION 9324. Initial applicability; health and family services.

(1) HEALTH INSURANCE RISK–SHARING PLAN. With respect to changes in plan design, including covered expenses and exclusions, deductibles, copayments, coinsurance, and out–of–pocket limits, the treatment of sections 149.11, 149.14 (3) (intro.) and (a) to (r), (4), (5) (d) and (e), and (8), 149.146 (1) (b) and (2) (a), (am) 4. and 5., and (b) (intro.) and 1., 149.15 (3) (b), and 149.17 (4) of the statutes first applies to the plan year beginning on January 1, 2004.

(END)

D-note

INSERT 4–19

The department shall determine the manufacturers of prescription drugs that are sold, or otherwise provided, to persons in this state who receive health care coverage benefits under publicly funded health care coverage programs in this state, such as the plan, the Medical Assistance program under subch. IV of ch. 49, the Badger Care health care program under s. 49.665, and the prescription drug assistance for elderly persons program under s. 49.688. The drug manufacturers specified by the department under this subsection

(END OF INSERT 4–19)

INSERT 5–1

Each drug manufacturer's proportion of participation

(END OF INSERT 5–1)

INSERT 5–3

prescription drugs sold or otherwise provided to the persons specified in sub. (1)

(END OF INSERT 5–3)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2476/P4dn
PJK:...

1. In this version, the pharmacy examining board is still the assessing agent for drug manufacturer assessments and still has the authority to impose a forfeiture for nonpayment. This may not be what you wanted, but DHFS does not seem to have more of a connection to drug manufacturers than the pharmacy examining board.

2. If, in the previous versions, the connection between drug manufacturers and HIRSP (as justification for the assessments) was the high cost of drugs and its relationship to persons not being able to obtain affordable insurance coverage, the current version no longer has even that connection. There does not seem to be a reasonable, rational basis for the making a separate, distinct classification for drug manufacturers that provide drugs to persons with coverage under publicly funded health care programs. The only basis for carving out the group seems to be administrative ease in obtaining the information necessary to determine the assessment. As such, this version seems to violate the Equal Protection Clause of the U.S. Constitution.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.state.wi.us

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2476/P4dn
PJK:kmg:jf

May 6, 2003

1. In this version, the pharmacy examining board is still the assessing agent for drug manufacturer assessments and still has the authority to impose a forfeiture for nonpayment. This may not be what you wanted, but DHFS does not seem to have more of a connection to drug manufacturers than the pharmacy examining board.

2. If, in the previous versions, the connection between drug manufacturers and HIRSP (as justification for the assessments) was the high cost of drugs and its relationship to persons not being able to obtain affordable insurance coverage, the current version no longer has even that connection. There does not seem to be a reasonable, rational basis for making a separate, distinct classification for drug manufacturers that provide drugs to persons with coverage under publicly funded health care programs. The only basis for carving out the group seems to be administrative ease in obtaining the information necessary to determine the assessment. As such, this version seems to violate the Equal Protection Clause of the U.S. Constitution.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.state.wi.us

8-21

Pat Osborne WALHI
Charlie Morgan
Dick Sweet
Bob Wood
Sandy Lonergan
Nancy Wanzel
Wayne, Gray
me & Catherine
Joe Strohl (Lates)

Pat Osborne: funding base-broadening

a portion of his assessment – diff formula to get at self-insured "covered lives"
higher burden on stop-loss carriers

(2) pharm. mgmt. – assessment based on prorata share of drugs used in HIRSP "nexus"
(rebate is also a possibility)

(3) incorporate means-testing into the program
>$100,000 ↑ premium
put on incremental scale in statute
maybe/maybe not? (index to inflation → the income)

[redacted]

(4) Cost control: restore gov. auth. to HIRSP bd
plan design, governance → would have to specify who, what
cover / repeal

benefit design & cost-sharing — out of state & by rule
(possibly give bd auth to get at stop loss carriers – rather than explicitly in statute)

Bob Wood: bd auth to modify imposition of assessment
(by rule?)
↳ would have to be

want testing ⇒ need to get the question on application

(GPR → at least some to ↑ the subsidies)

Nancy Wenzel: broader funding base
have drugs as riders or carve out drug benefit & combine it with a longer plan
(like the state)
make drug benefit more cost-effective

governance ⇒ more auth to bd like
support guidelines entails w/ flexibility to bd
w/in those guidelines

wants more info on application form

problems w/ both application info & verification of info provided (& that info to be compiled & collected)

requirement is too loose – need to be rejected by only one insurer
require at least 2 insurer rejections

⇒ stat – requirement that info is compiled & collected in data base
require admin contract to require this ↑

~~[illegible]~~

application form must include economic, demographic, employment info & info provided must be verified & compiled into a data base

Joe Stroble: additional funding sources
governance → more flexibility for bd

drug companies
bd determines how to do assessment or rebate supplemental

USE P4

drug manufacturers

any change to bd appointment?
(appt by gov?)

develop a list of Q's → run this by Marc first
for lobbyists

GPR → sunrise
1st part eliminate subsidy part paid by ins providers

$5,000,000
$5,000,000

Dept gov to include this in next budget

→ GPR funding

means testing → any ↑ = prem paid would be used to ↓ prem for low-income

↑ subsidy amt in s. 149.165

target ↓

low-income + older (high cost bis)

gather info + bd should make the change in

bd

target low-income / high cost

w/ additional prem $

something to 149.165

Joe Strahl Blue Cross 251-0900

SANDY LONERGAN WEA TRUST 661-6774

Nancy Wenzel Wis Assoc of Health Plans
255-8599

Pat Osborne WAHI 258-9506
osborne@hamilton-consulting.com

BOB WOOD WPS 608-583-7606 CELL 444-3557
bwoodx2@mhtc.net

Kahler, Pam

From: Sweet, Richard
Sent: Friday, August 22, 2003 9:00 AM
To: Kahler, Pam
Subject: RE: HIRSP draft

I think they wanted whatever comes in from the drug companies to be taken off the top from the 40% and the rest apportioned equally between the providers and the insurers.

-----Original Message-----
From: Kahler, Pam
Sent: Thursday, August 21, 2003 4:34 PM
To: Sweet, Richard
Cc: Wischnewski, Marne; Morgan, Charlie
Subject: RE: HIRSP draft

In the P4, the breakdown is 60/40, and the drug companies, providers, and insurers are each responsible for one-third of the 40%. I guess the language will, to some extent, depend on whether the drug companies pay rebates or assessments.

-----Original Message-----
From: Sweet, Richard
Sent: Thursday, August 21, 2003 4:12 PM
To: Kahler, Pam
Cc: Wischnewski, Marne; Morgan, Charlie
Subject: RE: HIRSP draft

Pam,

Just a few quick observations:

1. You probably want to cover drug manufacturers and labelers. This is what was done in the PDL bill that Robin Ryan prepared (AB 355, page 18, lines 9 and 10).

2. You should probably specify that the breakdown is 60/40--the drug company rebate is subtracted from the 40 and the remainder is split equally between the insurers and providers.

I can look at this in more detail, but wanted to get back to you quickly before you leave on vacation.

Dick

-----Original Message-----
From: Kahler, Pam
Sent: Thursday, August 21, 2003 3:59 PM
To: Sweet, Richard
Cc: Wischnewski, Marne; Morgan, Charlie
Subject: HIRSP draft

Hi, Dick:

Here is my list of questions/comments for the HIRSP bill. Do you have any additions? Have any of my questions been resolved?

I. Plan governance.
Are the provisions in LRB-2476/P4 (P4) okay? If not, what should be changed?

II. Funding.

a. Insurers.

Section 7 of P4 requires the board to apportion the insurer assessments. Is this okay or should there be specific language regarding "covered lives"? no

b. Pharmaceutical manufacturers.

1. Should this be limited to manufacturers or should distributers be included? labelers instead

2. Should there be any other limitations on manufacturers, such as those that manufacture drugs used under the plan? (Do we have this info?) yes — HIRSP only

3. Should the participation (assessment or rebate) be in statute or should the board determine whether drug manufacturers pay an assessment or provide rebates, and develop a methodology for determining the assessment or negotiate the rebates?

4. See Section 10 of P4. Can anything from this be used or should this be replaced altogether?

III. Means-testing.

a. See Section 59 of P4. Is this adequate for the means-testing provision, or should the actual schedule be in the statutes? I would need the specific information if the schedule is to be set out in the stats.

b. Require or allow the incomes to be modified annually by the board in accordance with the consumer price index? (This could be discetionary, too.)

V. Board.

a. Any changes to make-up? add pharmacist → no

b. Should the governor appoint members instead of the secretary of DHFS? Should the governor nominate and the senate appoint?

c. See Section 53 of P4. Should those changes be retained?

V. Eligibility.

Change s. 149.12 (1) (a) to a rejection by at least *two* insurers.

VI. Application.

a. Require the application form to include specific information, and provide me with a list of what information must be included.

b. In the alternative, require the board to modify the application form to include additional economic, demographic, and employment information.

c. Should there be a requirement that the information on the application form be verified? If so, by whom and before eligibility is determined?

d. Require that the information from the application forms be compiled into a database so that it can be used for various purposes related to plan administration. yes

e. Require instead that all (or some) of the above be made requirements in the contract for plan administration.

VII. Drug benefit. (Based on comments from Nancy Wenzel)

a. Require that the drug benefit be provided as a rider?

b. Require that the drug benefit be combined with another drug program, such as the one available to state employees? no changes to current law

VIII. Use of additional premium.

Something similar to the language in Section 59 of P4 would be added so that the board uses additional premium collected from high income enrollees for low-income enrollees that pay a high premium due to their age category.

Thanks for your input.

Pam

Kahler, Pam

From: Sweet, Richard
Sent: Friday, September 12, 2003 1:27 PM
To: Kahler, Pam
Cc: Wischnewski, Marne
Subject: HIRSP

Pam:

I'm following up on our conversation on the phone. When Marne and I spoke with Gregg, he decided he would like the new revenue from increased premiums on higher income persons to be used just for further premium reductions for lower income persons (i.e. beyond the reductions specified in s. 149.165).

Dick

p4 on 1/3, 1/3, 1/3

add

labelers (substitute for distributors)

drug manufacturers & labelers (use def from Robin's bill)

I. p4 but add 149.115 "in consultation w/ dept & bd"

II. p3 l 12 & 13 out

2. derived from HIRSP (not all other programs)

(use assessment instead of rebate)

new provision — if a drug mnfr or labeler participates in MA, Badger Care, or Senior Care must provide drugs to HIRSP

III. no rate schedule in statutes

for low-income

allow bd to further reduce amts

bd can adjust ~~to~~ percentage reduce premium

p19 line 8 shall

Do

like 149.165 (3m) → bd may alter % in 149.165

but ↑ in premium will go into subsidy pot (to reduce)

& ~~excess~~ premium go into subsidy language

No GPR at all

use excess for
long-term

149.165 (2) → bd may provide ↓ premiums for low income

shall use excess for ↓ premiums

* uncertain about use of excess premium — Subsidy or to reduce premium

BD
Void → one representative of Pharmaceutic Research & Manufacturers Assoc by American

PhRma

✓ * Members slb appointed by secretary (as in current law)

✓ V repetitive by 2 —
149.12 (1)(a) → 2 instances
(1)(am) → add repetition
(b) → " "
(c) → " "

VI application – 3 things:
✓ a) dept verify applicants employment
Rates + utilization is available
(see s. 49.475) using
that apply — + periodically reverify

✓ (b) require that employment status, geographic info be entered into database
(maintain & regularly update)

✓ c) dept to bd — report quarterly on this info
dept report to bd quarterly

✓ get rid of planning dd staff

✓ delete GPR stuff — constas

✓ p24 line 2 → Dec 31, 2003

✓ p 24, line 4 → Jan 1, 2005 for plan design

(the rest is Jan 1, 2004 ?)

✓* add: any fed grant dollars rec'd for operation high risk pools must come off the top before the rest of the formula
(same as GPR was)

* 149.143 (5)(b)

p. 14, l 5 to 10

put new) rate language in pla admin to rate setting

*
s 149.25 sec 69 keep dept conducting but consult w/ bd

(use excess in 149.143(2m)(a) eq a/c over 10,000,000 for low income

Decision:

shall
all excess ↗ go ~~to~~

↓ premiums
shall

(~~not~~ reduce subsidy
amt that insurers
pay but reduce
premium that

↑ subsidy to ↓ premium that
low income pay)

Wood Comment:

This has to do with the problem that the current plan administrator cannot calculate the provider contribution on a per claim basis. I thought that deleting this language would be necessary in order to allow this problem to be properly addressed in the RFP, but deleting this language just confuses everybody. So, instead of deleting the sentence, add a new sentence to read: Whenever a claim is processed for payment, the adjustment of a provider's payment rate to meet the provider's specified portion of the plan costs shall be calculated and applied on a per claim basis, and shall be disclosed as such on the claim explanation of benefits (EOB) form provided to the policyholder and the provider.

LRB-2476

9-18 Rep Underheim called

do not give bd discretion to determine ins. assessments (including treating stop loss ins. differently)

~~Harsdorf~~, go back to current law that's based on premium collected (health care coverage revenue) for insurer assessments